General Assembly

Amendment

February Session, 2024

LCO No. **5216**

Offered by:
SEN. LESSER, 9th Dist.
SEN. CABRERA, 17th Dist.
SEN. GORDON, 35th Dist.

To: Senate Bill No. **366** File No. 262 Cal. No. 188

"AN ACT CONCERNING MEDICAID."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective January 1, 2025*) (a) As used in this section:

(1) "Covered person" has the same meaning as provided in section 38a-472*l* of the general statutes;

(2) "Denominator" means the total amount of premium revenue, excluding federal and state taxes, any licensing and regulatory fees paid and any other payments made pursuant to federal law;

(3) "Dental plan" has the same meaning as provided in section 38a-577 of the general statutes;

(4) "Dentist" means any individual licensed and registered as a dentist pursuant to chapter 379 of the general statutes;

(5) "Health carrier" has the same meaning as provided in section 38a-591a of the general statutes;

(6) "Medical loss ratio" means a percentage of premium dollars spent on patient care expressed as a fraction, in which the numerator is divided by the denominator; and

(7) (A) "Numerator" means the sum of the (i) amount expended for clinical dental services provided to enrollees, as defined in regulations adopted by the Insurance Commissioner, in accordance with the provisions of chapter 54 of the general statutes, (ii) amount expended on activities that improve dental care quality, as defined in regulations adopted by the commissioner, in accordance with the provisions of chapter 54 of the general statutes, and (iii) amount of claims payments identified through fraud reduction efforts.

(B) "Numerator" does not include (i) administrative expenditures for calculating and reporting the medical loss ratio, (ii) financial administration expenses, (iii) marketing and sales expenses, (iv) distribution expenses, (v) claims operation expenses, (vi) medical administration expenses, including disease management, care management, utilization review and medical management activities, (vii) network operation expenses, (viii) charitable expenses, (ix) board, bureau or association fees, (x) state and federal taxes, including, but not limited to, assessments, or (xi) payroll expenses.

(b) The Insurance Commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to define clinical dental services, consistent with expenditures for clinical services used for reporting of the medical loss ratio by any health carrier offering dental plans in this state.

(c) If the annual medical loss ratio for a health carrier's plan offered pursuant to this section is less than the minimum medical loss ratio pursuant to subsection (d) of this section, such health carrier shall refund the excess premium to such health carrier's covered persons and covered groups, excluding federal and state taxes, and licensing and

regulatory fees paid.

(1) Not later than thirty days after a health carrier determines its medical loss ratio is less than the minimum medical loss ratio pursuant to subsection (d) of this section, such health carrier shall communicate to all covered persons and covered groups that were covered under dental plans during the immediately preceding twelve-month period that such covered persons and covered groups qualify for a refund on the premium paid, or, if such covered persons or covered groups renewed such coverage with such health carrier, a credit on such premium due for the subsequent twelve-month period may be granted.

(2) Any refund issued by such health carrier shall be provided to such covered persons or covered groups not later than one hundred twenty calendar days after such ratio is reported to the commissioner.

(3) The total amount of all refunds issued by such health carrier pursuant to the provisions of this subsection shall equal the amount of such health carrier's earned premium that exceeds the amount necessary to achieve the medical loss ratio pursuant to subsection (d) of this section, calculated using data reported by such health carrier in such form as the commissioner prescribes.

(4) The commissioner may authorize a waiver or adjustment of the refund required under the provisions of this subsection, provided the commissioner determines that issuing refunds would result in financial impairment for the health carrier.

(d) The medical loss ratio established in accordance with the provisions of this section shall be a minimum of eighty-five per cent.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish activities that improve dental quality that align with similar activities related to quality that are permitted for the determination of the medical loss ratio by health carriers offering managed care plans in this state. Such activities shall not include activities that are focused primarily on (1)

cost containment, (2) the management of claims adjudication systems, (3) retrospective or concurrent utilization review, (4) the development of provider networks, (5) the negotiation of dental provider contracts, or (6) credentialing providers.

(f) Not later than July 1, 2025, and annually thereafter, each health carrier offering an individual or group dental plan shall report (1) medical loss ratio information for the immediately preceding calendar year, (2) plan information, and (3) a financial statement to the commissioner and in a format determined by the commissioner. Not later than forty-five days after receipt of such reports by the commissioner, the commissioner shall post such reports on the Insurance Department's Internet web site. If the commissioner determines that verification of any information contained in any such report provided by a health carrier is necessary, the commissioner shall provide at least thirty days' notice to such health carrier before the commissioner examines such report. Such health carrier shall have thirty days from the date of such examination to submit such information required by the commissioner.

(g) (1) Notwithstanding any provision of the general statutes, each health carrier offering dental plans in this state shall submit (A) plan information, (B) an annual financial statement pursuant to the provisions of subsection (k) of this section, which shall include the current and projected medical loss ratio for claims in this state, (C) the total number of claims for such health carrier's dental plans, (D) projected administrative expenses, and (E) financial information, including, but not limited to:

(i) All sources of income;

(ii) Expenses, including, but not limited to, underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(iii) Marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iv) Distribution expenses, including, but not limited to, such health carrier's subsidiaries and affiliates, as applicable;

(v) Claims operating expenses, including, but not limited to, adjudication, appeals, settlements and expenses associated with paying such claims;

(vi) Medical administration expenses, including, but not limited to, disease management, care management, utilization review and medical management activities;

(vii) Network operation expenses;

(viii) Charitable expenses;

(ix) Board, bureau or association fees;

(x) State and federal taxes, and assessments; and

(xi) Payroll expenses.

(2) Unless otherwise determined by the commissioner, the expenditures, expenses and fees set forth in subparagraph (B) of subdivision (7) of subsection (a) of this section shall be deemed to be administrative cost expenditures for the purposes of calculating and reporting the medical loss ratio pursuant to this section.

(h) Notwithstanding any provision of the general statutes, any health carrier offering dental plans in this state shall file with the commissioner group product base rates and any change to rating factors for such dental plans that are to be effective on January first of each calendar year. The commissioner shall not approve (1) any proposed change to such health carrier's base rates if the commissioner determines that such base rates are excessive, inadequate or unreasonable, as compared to benefits charged by such health carrier, or (2) any change to group rating factors that the commissioner determines is discriminatory or not actuarially sound.

(i) (1) If any health carrier files a base rate change pursuant to this section, and the administrative expense loading component, not including federal and state taxes, and assessments, increases by more than the immediately preceding calendar year percentage increase in the dental services consumer price index for urban consumers, or if such health carrier's reported contribution to surplus exceeds 1.9 per cent, or if the aggregate medical loss ratio for all dental plans offered under this section is less than the applicable percentage set forth in subsection (d) of this section, such health carrier's base rate shall be presumptively deemed excessive and rejected by the commissioner.

(2) If such health carrier's proposed rate change is presumptively deemed excessive and rejected by the commissioner pursuant to subdivision (1) of this subsection:

(A) Such health carrier shall notify all covered employers and covered persons under the group plan of the determination made pursuant to subdivision (1) of this subsection and that such determination is subject to a hearing before the commissioner;

(B) The commissioner shall conduct a public hearing on such rate change; and

(C) The Attorney General may intervene in such public hearing and conduct its own investigation to ensure compliance with the provisions of this subsection.

(3) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this subsection.

(j) (1) If the commissioner, after conducting a public hearing pursuant to subparagraph (B) of subdivision (2) of subsection (i), disapproves a health carrier's proposed rate change, the commissioner shall provide written notice of such decision not later than forty-five calendar days before the effective date of such health carrier's proposed rate change.

(2) Not later than ten calendar days after receipt of such notice, the health carrier may submit a request to the commissioner for a public hearing. Such public hearing shall be held not later than fifteen calendar days after such health carrier submits such request. Not later than thirty calendar days after such public hearing held in accordance with the provisions of this subdivision, the commissioner shall issue a written decision approving, disapproving or modifying such proposed rate change. No health carrier shall implement such disapproved rates after a public hearing, unless the commissioner reverses such disapproval after such public hearing or a court vacates the commissioner's decision.

(k) Each health carrier shall submit an annual financial statement to the commissioner that contains such health carrier's plan information and costs from the immediately preceding calendar year. Such financial statement shall be itemized, as applicable, by:

(1) Market group size, including:

(A) Individual;

(B) Small groups of (i) at least one but not more than five members, (ii) at least six but not more than ten members, (iii) at least eleven but not more than twenty-five members, and (iv) at least twenty-six but not more than fifty members;

(C) Large groups of (i) at least fifty but not more than one hundred members, (ii) at least one hundred one but not more than five hundred members, (iii) at least five hundred one but not more than one thousand members, and (iv) more than one thousand members; and

(2) Line of business, including:

(A) Any stand-alone dental plan that covers oral surgical care, dental services, dental procedures or dental benefits covered by any individual, general, blanket or group policy of health, accident and sickness insurance issued by any health insurer licensed to transact accident and health insurance in this state;

(B) Any oral surgical care, dental services, dental procedures or dental benefits covered by any stand-alone individual or group dental medical service plan issued by a nonprofit medical service corporation;

(C) Any oral surgical care, dental services, dental procedures or dental benefits covered by any stand-alone individual or group dental medical service plan issued by a dental service corporation;

(D) Any oral surgical care, dental services, dental procedures or benefits covered by any stand-alone individual or group dental health maintenance contract issued by a health maintenance organization;

(E) Any oral surgical care, dental services, dental procedures or dental benefits covered by any stand-alone individual or group preferred provider dental plan issued by a preferred provider arrangement; and

(F) Any stand-alone group dental health insurance plans.

(3) The following information:

(A) Direct premiums earned;

(B) Direct claims incurred;

(C) Medical loss ratio;

(D) Number of members;

(E) Number of distinct groups covered;

(F) Number of lives covered;

(G) Realized capital gains and losses;

(H) All sources of net income;

(I) Accumulated surplus;

(J) Accumulated reserves;

(K) Risk-based capital ratio, based on a formula adopted by the National Association of Insurance Commissioners;

(L) Financial administration expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(M) Marketing and sales expenses, including advertising, member relations and member enrollment expenses;

(N) Distribution expenses, including such distribution expenses to such health carrier's subsidiaries and affiliates, including commissions, producers and broker and benefit consultant expenses;

(O) Claims operation expenses, including adjudication, appeals, settlements and expenses associated with paying claims;

(P) Dental administration expenses, including disease management, utilization review and dental management expenses;

(Q) Network operational expenses, including contracting, dentist relations and dental policy procedures;

(R) Charitable expenses, including any contributions to tax-exempt foundations and community benefits;

(S) Board, bureau or association fees;

(T) Any miscellaneous expenses identified by expense, including any expense not included in subparagraphs (A) to (R), inclusive, of this subdivision;

(U) Payroll expenses and the number of employees on such health carrier's payroll;

(V) State and federal taxes, and assessments; and

(W) Any other information deemed necessary by the commissioner.

(4) Each health carrier required to submit an annual financial statement pursuant to this subsection that provides administrative services to at least one self-insured group shall include, in an appendix to such financial statement, the following information:

(A) The number of such health carrier's self-insured customers;

(B) The aggregate number of members in all of such health carrier's self-insured customers;

(C) The aggregate number of lives covered in all of such health carrier's self-insured customers;

(D) The aggregate value of direct premiums earned for all of such health carrier's self-insured customers;

(E) The aggregate medical loss ratio for all of such health carrier's self-insured customers;

(F) Net income;

(G) Accumulated surplus;

(H) Accumulated reserves;

(I) The percentage of such health carrier's self-insured customers that include each of the benefits mandated for health plans offered by such health carrier;

(J) Administrative service fees paid by such health carrier's self-insured customers; and

(K) Any other information deemed necessary by the commissioner.

(5) Any health carrier that fails to submit an annual financial statement pursuant to this subsection by April first, annually, shall be assessed a penalty not to exceed one hundred dollars per day.

(6) The commissioner shall post on the Insurance Department's

Internet web site all information collected by the commissioner pursuant to this subsection.

(7) The commissioner shall, from time to time, require each health carrier to submit such health carrier's data used to calculate the annual financial statement pursuant to the provisions of this subsection. The commissioner may use such data for purposes of conducting audits.

(8) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish financial statement reporting requirements for health carriers. The commissioner shall consult with other agencies of this state, the federal government and such health carriers that are required to comply with the provisions of this section, to ensure that such financial statement reporting requirements are not duplicative of existing reporting requirements set forth in the insurance regulations in this state.

(9) (A) If any health carrier submits a financial statement pursuant to the provisions of this subsection that includes a risk-based capital ratio on a combined entity basis that exceeds seven hundred per cent, the commissioner shall hold a public hearing not later than sixty days after receipt of such financial statement.

(B) During the public hearing conducted pursuant to subparagraph (A) of this subdivision, the health carrier shall submit testimony on (i) such health carrier's overall financial condition, (ii) such health carrier's continued need for additional surplus, and (iii) how, and in what proportion to the total surplus accumulated, such health carrier intends to dedicate any additional surplus (I) to reduce the cost of such health carrier's dental plans, (II) for dental care quality improvement, patient safety, and (III) for dental cost containment activities that were not conducted in previous years. Upon review of such testimony, the commissioner shall issue a final report on the results of such public hearing.

(10) Any reporting provisions required pursuant to this subsection may be waived by the commissioner for classes of health carriers that

the commissioner deems such reporting requirements to be inapplicable, provided the commissioner shall provide written notice of such waiver to the joint standing committee of the General Assembly having cognizance of matters relating to insurance.

(11) Notwithstanding any provision of title 38a of the general statutes, the provisions of this section shall apply to any dental plan issued by a health carrier licensed in this state, or through an intermediary of such health carrier. This section shall not apply to dental plans issued, delivered or renewed to a self-insured group or where the health carrier acts as a third-party administrator. Nothing in this section shall be construed to require a health carrier licensed in this state that does not issue dental plans to issue dental plans in accordance with the provisions of this section."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2025*	New section